IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003381

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF JENNIFER THOMAS

Findings of:	Coroner David Ryan
Delivered on:	15 May 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	24, 27-28 April 2023
Counsel Assisting the Coroner:	Paul Halley of counsel
Life Without Barriers:	Robert Harper of counsel
Keywords:	Disability residential care – Injuries observed post-mortem – bruising

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BACKGROUND

1. On 28 June 2021, Jennifer Thomas (**Jennifer**) was 65 years old when she died at a disability residential care facility operated by Life Without Barriers (**LWB**) in Dickson Street, Mount Waverly. She lived in the house with three other residents and was cared for by staff employed or contracted by LWB.

2. Jennifer was born on 13 February 1956. She suffered from phenylketonuria (**PKU**), a rare metabolic disorder, which resulted in her having an intellectual disability. Her medical history included epilepsy, asthma and dysphagia. Her epilepsy was well-managed with medication, as was her dysphagia with proper diet and supervision.

3. Jennifer had been living in care since she was about 8 years old. She moved into the house at Dickson Street about 15 years prior to her death. Initially she was able to walk and attend to aspects of her daily living with some independence, such as feeding and toileting. However, her mobility and functioning had reduced over the years and at the time of her death she required a specialised wheelchair and the use of a sling and hoist to transfer her to and from her bed.

4. Jennifer was non-verbal but she was able to communicate by using some words together with gestures and facial expressions.

5. Jennifer's siblings, Catherine Vandenberg, Mark Thomas and Anne Maher, participated in the investigation by way of providing statements for the coronial brief and attending the inquest. Ms Maher delivered a moving coronial impact statement in Court on 28 April 2023. It is clear that Jennifer was dearly loved by her family and is remembered with warmth and affection by the staff at Dickson Street.

6. Jennifer's records with LWB demonstrate that staff at Dickson Street were responsive to changes in her presentation that required medical attention. For example, she was transferred to Knox Private Hospital on 9 April 2021 when she was observed to have an increased cough with a runny nose. She was treated for aspiration pneumonia with antibiotics and intravenous fluids and discharged on 16 April 2021.

7. Jennifer also attended her General Practitioner (**GP**) regularly, including on 9 June 2021 when staff noticed a bruise on her right shoulder after she appeared to have slipped out of her low bed. The GP noted that Jennifer did not appear to be in pain during her examination.

CORONIAL INVESTIGATION

Jurisdiction

8. Jennifer's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Pursuant to section 52(1) of the Act, I determined that an inquest should be held into Jennifer's death which occurred on 24, 27 and 28 April 2023.

9. The Coroners Court of Victoria (**Coroners Court**) is an inquisitorial court.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

[1] Section 89(4) of the *Act.*

13. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[2]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[3] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[4]

14. These powers are the vehicles by which the prevention role may be advanced.

15. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[5] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[6]

16. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[7]

IDENTITY OF THE DECEASED

17. On 28 June 2021, Jennifer was visually identified by Erenia Taberao.

18. Identity is not in dispute and requires no further investigation.

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[2] Section 72(1) of the Act.
[3] Section 67(2) of the Act.
[4] Section 72(2) of the Act.
[5] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[6] *Keown v Khan* (1999) 1 VR 69.
[7] (1938) 60 CLR 336.

MEDICAL CAUSE OF DEATH

19. On 1 July 2021, Dr Brian Beer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy upon Jennifer's body. In a report dated 22 February 2022, Dr Beer noted a subcapital fracture of the left humerus and a spiral fracture of the lower right femur with associated marked soft tissue haemorrhage/bruising.

20. Dr Beer commented that the radiological, macroscopic and microscopic features of the fractures and associated soft tissue injury suggest a relatively acute timeframe for their occurrence, most likely in the order of hours to days.

21. The post-mortem computed tomography (**CT**) scan results were reviewed by forensic radiologist Dr Chris O'Donnell and showed background bone osteoporosis with an increased susceptibility to sustaining fractures.

22. Toxicological analysis of post-mortem blood samples identified the presence of valproic acid[8] and levetiracetam at therapeutic levels.[9]

23. Dr Beer formulated the cause of death as complications arising from fractures of the left humerus and right femur with associated soft tissue haemorrhage, and he identified microcephaly, diffuse white matter atrophy and inferior frontal encephalomalacia as contributing factors.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

24. On 27 June 2021, the day before her death, Jennifer was visited by her sisters, Catherine and Anne. They noted that she did not appear to be her usual self, was less communicative and looked sad.

25. Jennifer was cared for overnight on 27 June 2021 by LWB staff member Fiona McCole. Ms McCole had been working at Dickson Street for 15 years and knew Jennifer well.

[8] Valproic acid is used to treat epilepsy.
[9] Levetiracetam is an antiepileptic used for the control of partial onset seizures.

Ms McCole recalled changing her on about three occasions overnight for toileting and she did not observe any bruising on her legs during this process. Further, she recalled that Jennifer slept relatively well and did not exhibit any unusual behaviour or indicate that she was in pain which she would do by putting her hand to her head.[10]

26. At around 7.00am on 28 June 2021, two other staff members arrived at Dickson Street to take over the responsibility for caring for the residents after the conclusion of Ms McCole's shift. They were the House Supervisor, Erenia Taberao, and agency staff, Veronicah Wainaina. Ms Taberao had been working at Dickson Street for 15 years and know Jennifer well but it was Ms Wainaina's first time working at Dickson Street.

27. Ms Taberao and Ms Wainaina bathed Jennifer in her bed during the morning. They observed Jennifer's unclothed body during this process and did not observe any bruising.[11]

28. After bathing Jennifer, Ms Taberao and Ms Wainaina clothed her and transferred her to her wheelchair using the sling and hoist. Ms Taberao was experienced in using the sling and hoist and had been trained in its use by an occupational therapist. She supervised Ms Wainaina in assisting with the transfer and Ms Taberao recalled that "*everything went smoothly*". After being transferred into her wheelchair, Jennifer was transferred to the lounge area.[12]

29. At around 3.00pm, LWB employee Kathryn Holder commenced her shift at Dickson Street. She had been working at Dickson Street since early 2019 and she also knew Jennifer well. Between 3.15pm and 3.45 pm, Ms Holder fed Jennifer her afternoon tea while Ms Wainaina was out walking with another resident and Ms Taberao attended to administrative tasks. Ms Holder noted that Jennifer was vocalising and appeared to be her normal self.[13]

[10] CB23-24; T9-T13.
[11] T20-T21; T48.
[12] T23-T25; T29; T34; T37-T38; T48; T50 & T52.
[13] CB19; CB21; T53; T80; T83.

30. At around 4.00pm, Ms Taberao left for the day while Ms Holder was in the kitchen preparing dinner for the residents. At around 4.10pm, Ms Holder noted that Jennifer had gone "*a little bit quiet*" and she turned around and observed that her chin was down on her chest. She thought Jennifer had gone to sleep and moved the wheelchair into the dining area and tilted the chair back to relieve her neck. At this stage, Ms Holder noted that Jennifer's head "*flopped to the side and her eyes were wide open*".[14]

31. At this moment, Ms Wainaina returned to the house and was notified by Ms Holder that Jennifer was unresponsive. Ms Wainaina contacted emergency services at 4.20pm and handed the phone to Ms Holder. Guided by the operator, Ms Holder wheeled Jennifer into her room where she and Ms Wainaina lifted her out of the chair, turned her about 90 degrees, and transferred her onto a mat on the floor where they took turns performing cardiopulmonary resuscitation (**CPR**). They were performing CPR for about 7 minutes when Fire Rescue Victoria and Ambulance Victoria arrived and took over the emergency response at 4.29pm. Jennifer was pronounced deceased at 4.32pm.[15]

32. Inconsistent evidence was given in relation to how Jennifer was lifted from her chair and transferred to the floor. Ms Holder stated that she and Ms Wainaina were on either side of Jennifer when they lifted her from the chair, each with one of their shoulders under her arms and each with a hand underneath her near the back of the knees.[16] Ms Wainaina stated that either she or Ms Holder (she could not recall which) lifted the upper part of Jennifer's body from the chair while the other lifted her legs.

SOURCES OF EVIDENCE

33. Victoria Police assigned Senior Constable John Hughes to be the Coroner's Investigator for the investigation into Jennifer's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from Jennifer's family, the forensic pathologist, her GP and staff who cared for Jennifer at Dickson Street. The

[14] T23-T25; T29; T34; T37-T38; T48; T50 & T52.
[15] CB350-354; T56-T60; T87-T94.
[16] T64; T91-T92.

Court also obtained reports from a forensic radiologist and an occupational therapist. Further, LWB commissioned expert reports from a geriatrician and another radiologist.

34. The inquest ran over 3 days and evidence was given by the following witnesses:

    (a) Veronicah Wainaina (Agency staff)

    (b) Kathryn Holder (former LWB staff);

    (c) Erenia Taberao (LWB House Supervisor);

    (d) Fiona McCole (former LWB staff);

    (e) Dr Brian Beer (forensic pathologist);

    (f) Dr Chris O'Donnell (radiologist);

    (g) Joanne Houston (occupational therapist);

    (h) Adjunct Professor Tuly Rosenfeld (**Adj Prof Rosenfeld**) (geriatrician – retained by LWB);

35. The evidence of the experts was given concurrently on 27 April 2023. In the week prior to the inquest, conclaves were convened for the experts to discuss in private the issues on which they agreed and disagreed. Dr Michael Jones, a radiologist retained by LWB was not available to give evidence at the inquest due to illness but he did participate in a conclave with Dr O'Donnell.

36. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief, and the submissions made by counsel assisting and LWB following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

SCOPE OF THE INQUEST

37. I determined to hold an inquest into Jennifer's death because she was a vulnerable person who required care for her day-to-day living, and she was discovered to have fractures to her left humerus and right femur the cause of which were not clear.

38. The scope of the inquest was *how* and *when* Jennifer sustained the fractures.

HOW AND WHEN DID THE FRACTURES OCCUR

Nature of the fractures

39. From their review of the post-mortem CT scans, Dr O'Donnell and Dr Jones agreed as follows:

    a) Jennifer had generalised (but not extreme) osteoporosis;

    b) There was an impacted fracture of the left neck of humerus with associated soft tissue swelling indicative of an axial load to the left upper limb (ie, applied force to the elbow or wrist/hand);

    c) There was an impacted, rotated right supracondylar femur with associated soft tissue swelling indicative of an axial load to the right lower limb (ie, applied force to the knee or foot);

    d) The fractures would be expected to be associated with bruising/swelling, deformity and pain; and

    e) The swelling indicates that the fractures are acute (ie, occurring within hours or days prior to death).[17]

[17] CB417a-417b.

Degree of force required

40. Dr O'Donnell and Dr Jones agreed that the degree of force required to cause the fractures would not have been trivial but given the underlying osteoporosis, would have been less than expected in an individual with normal bone density.

41. In evidence, Dr O'Donnell noted that there were no rib fractures associated with CPR and that a "*short, sharp force*" would have been required to cause the fractures.[18]

Significance of the bruising

42. Dr Beer noted in evidence that there was a significant amount of haemorrhage and bruising associated with the fractures and that it was generally difficult to accurately age bruising. He stated that he had never seen that volume of bleeding in a case where there had been no active circulation and that it would be unusual for that amount of haemorrhage to occur with CPR being the only mechanism for circulation. Dr Beer stated that it was possible that Jennifer still had some cardiac activity after she became unresponsive but before she passed away, which may also have contributed to a level of circulation that could explain the extent of the haemorrhage and associated bruising.[19]

43. Adj Prof Rosenfeld expressed the view that the bleeding into the tissues as a result of the fractures and the resulting bruising would likely have occurred during the resuscitation process.[20]

Pain response

44. In his report, Adj Prof Rosenfeld stated that:

> "*…the injuries would have been apparent to others – even in a non-verbal/even mute person suffering with severe intellectual disability – the deceased would have suffered with severe pain that would have led to easily evident and obvious observable features or clues of distress…the nursing personnel would more likely*

[18] T150; T155.
[19] T111-T114; T162.
[20] CB406; T121.

than not have observed and described some of the features of severe pain from the fracture as well as evidence of bruising".[21]

45. Adj Prof Rosenfeld stated in evidence that even in a generally unresponsive or mute person, the fractures observed in Jennifer's post-mortem imaging would result in "*outpourings of pain, anguish, screaming*" and that he would not be able to conceive of "*a scenario where she would have suffered those fractures and that it would not have been evident to all around that she was in pain and distress*".[22]

46. Ms Houston stated in her report and in evidence that if Jennifer had been conscious when she sustained the fractures, she would have been in significant pain, likely very vocal, and her carers would have been aware of her distress.[23]

47. Dr Beer stated in evidence that he would have expected a person experiencing the fractures observed in Jennifer's post-mortem imaging to be in "*agony*".[24]

48. Dr O'Donnell stated in evidence that he would expect a person with the fractures to have been in "*severe pain*" and that the degree of associated bruising and deformity would have been apparent to staff.[25]

Likely mechanism for the occurrence of the fractures

49. Adj Prof Rosenfeld and Ms Houston both gave evidence that Jennifer likely sustained the fractures in the process of her being lifted by Ms Holder and Ms Wainaina from her wheelchair and onto the mat on the floor in her room. They both spoke from their clinical experience of the practical and physical difficulties confronted by the staff in lifting an unresponsive body from a wheelchair (designed to keep a person in it) and onto the floor in a heightened and urgent situation"[26]

[21] CB400.
[22] T153
[23] T163; T139; T141-T142.
[24] T161.
[25] T147.
[26] T137.

50. Dr O'Donnell stated in evidence that it is "*absolutely possible*" that Jennifer could have sustained the fractures during her transfer to the floor if her upper left limb and lower right limb had "*come into contact with a surface abruptly*".[27]

51. Ms Houston stated in evidence that it was very unlikely that the fractures occurred while Jennifer was being transferred with the hoist and sling as it would not create the circumstances where there would be a short, sharp implementation of force. Dr O'Donnell agreed with Ms Houston, with the exception of the scenario where Jennifer had been dropped from the sling or knocked against an object.[28]

Cause of death

52. Dr Beer acknowledged in evidence that the formulation of Jennifer's cause of death depended upon the finding of facts that are accepted to have occurred on the day of her death. If the evidence of the staff who cared for Jennifer on 28 June 2021 is to be accepted, then Dr Beer considered that it was more likely that the fractures occurred during her transfer to the floor with the bruising caused by a combination of some cardiac output and CPR or CPR alone.[29]

53. Dr Beer considered that the haemorrhaging associated with the fractures would likely have had some contribution to Jennifer's cause of death if she maintained some level of cardiac output after she became unresponsive but before she died. However, he considered that it was not entirely possible to definitively determine whether the bruising was caused by a combination of some cardiac output and CPR or CPR alone.[30]

[27] T136-T137.
[28] T152-T153.
[29] T119-T120; T146-T149; T162.
[30] T162-T164.

54. Dr Beer stated that if he were to formulate Jennifer's cause of death now, after considering the evidence of the staff witnesses and upon the acceptance of that evidence, then it would be '*unascertained*'. He was not in a position to provide an opinion as to why she may have become unresponsive in her wheelchair, but he could not exclude an arrythmia or a Sudden Unexplained Death in Epilepsy (**SUDEP**).[31]

FINDINGS AND CONCLUSION

55. I am satisfied that the fractures to Jennifer's left humerus and right femur occurred when she was placed on the mat of the floor in her room after being transferred by Ms Holder and Ms Wainaina from her wheelchair. Further, it is not surprising that the physical and practical challenges of lifting Jennifer from the chair to the floor in urgent circumstances, combined with her osteoporosis, created a situation where an impact of her limbs with the floor would lead to fractures.

56. It is also unsurprising that there were inconsistencies in the recollections of Ms Holder and Ms Wainaina regarding the exact manner in which they lifted Jennifer from the wheelchair, given they were engaged in an emergency response in a heightened atmosphere of urgency and stress. There is no criticism of Ms Holder and Ms Wainaina and they are commended for their efforts.

57. I accept that the staff at Dickson Street gave truthful evidence to the best of their recollections and that the fractures were not caused by another undisclosed incident, such as Jennifer being dropped from the hoist during a transfer.

58. Jennifer was well cared for by the staff at Dickson House and they regarded her with respect, warmth and affection. The evidence discloses that they were responsive to changes in Jennifer's presentation and arranged for medical assessment by her GP when required.

[31] T115.

59. Had Jennifer sustained the fractures at some time prior to being transferred to the floor from her wheelchair, I am satisfied that she would have been in significant pain which would have been obvious to staff who would have responded to her distress and sought medical attention if required. Further, it is clear that staff did not observe any deformity or bruising on Jennifer's limbs when she was changed overnight on 28 June 2021 or later that morning when she was bathed in her bed.

60. I am satisfied that the haemorrhaging and bruising associated with the fractures was caused by a combination of cardiac output from Jennifer and CPR or CPR alone.

61. I consider that Jennifer had passed away when the fractures were sustained during her transfer to the floor or she was unconscious and dying from unascertained causes.

62. Having held an inquest into Jennifer's death, I make the following findings, pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Jennifer Thomas, born on 13 February 1956;

    b) the death occurred on 28 June 2021 at 20 Dickson Street, Mount Waverly, Victoria, from unascertained causes; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

63. The coronial investigation into Jennifer's death was necessary because she was a vulnerable person with disabilities who was discovered post-mortem to have serious fractures which could not at that stage be adequately explained.

64. The investigation has highlighted the importance of Advanced Care Planning under the *Medical Treatment Planning and Decisions Act 2016* (Vic) which involves the discussion of a person's end-of-life care by family, GPs, care workers and other health professionals. Such discussion can provide clarity and dignity for people (including those with

disabilities who lack decision making capacity) who are suffering from progressive illnesses where resuscitation may lead to poor outcomes.

65. There was no evidence of any Advanced Care Planning in Jennifer's case. A documented plan about her end-of-life care may have provided that resuscitation was not to be carried out in the event that she were to have been found unresponsive. Such a plan may have avoided the trauma experienced by staff in carrying out the emergency response, and avoided the uncertainty and anxiety experienced by family and staff in investigating the injuries subsequently found to have been sustained during the emergency response.

66. The responsibility to engage in discussion around Advanced Care Planning is a shared one. It is important that those involved, GPs and care staff in particular, are proactive in initiating conversations where appropriate and that the outcome of those discussions are documented.

I convey my sincerest sympathy to Jennifer's family.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) Unascertained".

I direct that a copy of this finding be provided to the following:

Anne Maher, Senior Next of Kin

Life Without Barriers, c/- Barry Nilsson Lawyers

Senior Constable John Hughes, Coroner's Investigator

Signature:

Coroner David Ryan

Date: 15 May 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.